DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155333	B. WING		06/21/2011
NAME OF P	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	
TWINE OF F	NO FIDER OR SOIT LIER			LONGEST ST	
PAOLI HI	EALTH AND LIVING	COMMUNITY INC	PAOLI	, IN47454	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	•	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was for	r the Investigation of	F0000	This plan of correcton is to serve a	,
	Complaint IN000	_	10000	Paoli Health and Living Communit	
	Complaint invoc	J91126.		credible allegaton of compliance .	, -
	Complaint IN000	091128- Substantiated,			
	•	iciencies are cited at		Submission of this plan of corrector does not constitute an admission by	
	F282, F312, and			Paoli Health and Living Communit	·
	,, and			or it's management company that	· I
	Survey dates:			the allegatons contained in the	
	June 20 and 21, 2011			survey report are a true and	
	June 20 and 21, 2	2011		accurate portrayal of the provision	ı
	Facility number:	000226		of nursing care and other services	in
	Provider number			this facility. Nor does this	
	AIM number: 10			submission consttute an agreement or admission of the survey	TIL .
	Anvi number. 10	0207730		allegatons .	
	Survey team:				
	Anne Marie Cray	vs RN			
	111110 1110110 0100)	, 0, 14.			
	Census bed type:				
	SNF: 11				
	SNF/NF: 92				
	Total: 103				
	Census payor typ	oe:			
	Medicare: 12				
	Medicaid: 76				
	Other: 15				
	Total: 103				
	Sample: 4				
	These deficiencie	es also reflect state			
		accordance with 410			
LABORATOR	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

UG1911

Facility ID:

000226

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 06/21/2011	
	PROVIDER OR SUPPLIEF	COMMUNITY INC	559 W	ADDRESS, CITY, STATE, ZIP CODE LONGEST ST IN47454	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	IAC 16.2. Quality review of 2011 by Bev Fau	completed on June 24, alkner, RN			
F0282 SS=D	facility must be prin accordance with plan of care. Based on observing record review, the implement intervito ensure a residual.	rided or arranged by the ovided by qualified persons heach resident's written ation, interview, and he facility failed to ventions in a plan of care ent dependent for care is toileted and repositioned	F0282	F 282 483.20(k)(3)(ii) SERV BY QUALIFIED PERSONS CARE PLAN1. Resident D toileted and repositioned2. residents that are depended care and toileting have bee	/PER was All nt for

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UG1911

Facility ID:

000226

If continuation sheet

Page 2 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		li i		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155333	B. WING		06/21/2011	
				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER		559 W	LONGEST ST		
	EALTH AND LIVING			IN47454	(X5)	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		
PREFIX	``	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG	ŧ	LSC IDENTIFYING INFORMATION)	TAG	· · · · · · · · · · · · · · · · · · ·	DATE	
	1	ours, for 1 of 3 residents		identified and are being toile and repositioned per the pla		
		ontinence care, in a		care.3. The systemic chang		
	sample of 4. Res	ident D		includes Charge Nurses will		
				provide rounds of all depend		
	Findings include:			residents at least twice a shift and		
				as needed to observe for to	-	
		4:20 P.M., during the		and repositioning of depend residents per the plan of	ent	
	initial tour, the A	dministrator indicated		care.Education has been		
	Resident D requi	red a Hoyer lift [a		provided to nursing staff		
	mechanical lift]	for transfer, and was		regarding toileting and		
	incontinent of bla	adder. Resident D was		repositioning of the dependence resident per the plan of care		
	observed sitting	up in a wheelchair in her		Unit Managers will observe	• • • • • • • • • • • • • • • • • • •	
	room at that time			of the dependent resident re		
				to toileting and repositioning		
	On 6/20/11 at 5:0	05 P.M., Resident D was		residents a day, 3 days a wo	эek	
	sitting in wheeld			residents a week for 5 months,	hs.	
				then 1 resident each week f		
	On 6/20/11 at 6:1	10 P.M., Resident D was		total of 12 months.The resul	its of	
		Ichair in her room.		these reviews will be discus	sed at	
		ionan m nor room.		the monthly facility Quality	lin a	
	On 6/20/11 at 7:0	05 P.M., CNA # 1		Assurance Committee meet and frequency and duration	· 1	
		sually laid (Resident D)		reviews will be adjusted as		
	1	30 P.M. and 8:00 P.M."		needed. Completion Date:	July	
				20, 2011		
	1 ^	ade at that time to do a				
		on Resident D whenever				
	she was laid dow	n.				
		25 P.M., CNA # 1 and				
	CNA # 2 indicate	ed they were going to lay				
	Resident D dowr	n in bed. As they lifted				
	the resident off o	f the wheelchair with the				
	Hoyer lift, a pude	dle of urine was observed				
	1 -	r cushion. The resident's				
		ed with urine. The				

000226

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU A. BUII		INSTRUCTION 00	(X3) DATE S	ETED	
		155333	B. WING	G		06/21/2	011
NAME OF I	PROVIDER OR SUPPLIER		·		ADDRESS, CITY, STATE, ZIP CODE LONGEST ST		
	EALTH AND LIVING				IN47454		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	resident's buttock	ks were wrinkled with					
	deep indentations from the brief, and was						
		CNAs put the resident to					
	I -	the bedpan to the					
	•	did not urinate. CNA # 1					
		dent was sitting up in the					
		they started their shift at					
	· ·	she'd been up awhile." ed she had offered to lay					
		•					
	the resident down earlier, and she had refused. CNA # 1 indicated the resident						
		eted or repositioned since					
	she had come on duty at 2:00 P.M.						
		•					
	The clinical reco	rd of Resident D was					
	reviewed on 6/21	/11 at 9:25 A.M.					
	Diagnoses includ	led, but were not limited					
	' '	estive Heart Failure, and					
	Dementia.						
	A Care Plan date	ed 2/21/11, indicated a					
	· ·	ential for skin breakdown					
	related to impair						
	1	nronic rash/redness to					
	abdominal folds	and periarea [sic]." The					
		ded: "Change incontinent					
		ossible after voiding or					
		t. Keep skin clean and					
	1 * *	hedule and prn [as					
		good pericare after					
	incontinence epis						
	1	bed check and PRN.					
	keposition while	up in wheelchair."					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155333	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMP 06/21/2	LETED
	PROVIDER OR SUPPLIER	COMMUNITY INC	559 W I	ADDRESS, CITY, STATE, ZIP COD LONGEST ST IN47454	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	problem of "Resincontinence R/T cognition and urgapproaches inclureach. Provide H Toilet upon rising [sic], hs [at bedtitoileting every two brief under reside incontinence paddincontinence paddinterview with the [DON] and Admindicated Reside with a Hoyer lift Resident D's toile before and after the cognition of the side of the continence padding and the complex side of the complex side of the cognition of the c					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155333	B. WIN			06/21/20	011
PAOLI HI		COMMUNITY INC		559 W L PAOLI,	LODRESS, CITY, STATE, ZIP CODE LONGEST ST IN47454		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0312 SS=D	of daily living rece to maintain good repersonal and oral. Based on observer record review, the aresident dependence was toileted and every 2 hours, for reviewed for incompany and the sample of 4. Resident Dependence of 5. Re	ation, interview, and e facility failed to ensure dent for care and toileting repositioned at least r 1 of 3 residents continence care, in a ident D : 4:20 P.M., during the dministrator indicated red a Hoyer lift [a for transfer, and was adder. Resident D was up in a wheelchair in her e.	F0	312	F 312 483.25(a)(3) ADL CARPROVIDED FOR DEPENDE RESIDENTS 1. Resident Described and repositioned 2. Aresidents that are dependent care and toileting have been identified and are being toilet and repositioned per the plar care. 3. The systemic changincludes Charge Nurses will provide rounds of all dependents at least twice a shift as needed to observe for toil and repositioning of dependents in the plan of care. Education has been provided to nursing staff regarding toileting and repositioning of the dependents in the plan of care. Unit Managers will observe to toileting and repositioning residents a day, 3 days a we for the next 30 days, then 3 residents a week for 5 months then 1 resident each week for	NT was All for ded n of ge ent ft and eting ent nt 4. care ated for 3 ek	07/20/2011
		10 P.M., Resident D was lehair in her room.			total of 12 months. The result these reviews will be discuss		

´		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155333	A. BUII	LDING	00	06/21/2011
		100000	B. WIN			00/21/2011
NAME OF	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE	
PAOLLH	EALTH AND LIVING	COMMUNITY INC		1	LONGEST ST IN47454	
		TATEMENT OF DEFICIENCIES				(V5)
(X4) ID PREFIX		CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DATE	
TAG	On 6/20/11 at 7:0 indicated they "u down between 7: A request was maskin assessment of she was laid down on 6/20/11 at 7:2 CNA # 2 indicated Resident D down the resident off on Hoyer lift, a pudd on the wheelchair brief was saturated resident's buttock deep indentations dark red. As the off bed, they offered resident, but she indicated the resident when 2:00 P.M., and "see CNA # 1 indicated the resident down refused. CNA # 1 had not been toiled she had started here inclinated the resident down refused. CNA # 1 had not been toiled she had started here inclinated the resident down refused. CNA # 1 had not been toiled she had started here inclinated the resident down refused. CNA # 1 had not been toiled she had started here.	sually laid (Resident D) 30 P.M. and 8:00 P.M." ade at that time to do a on Resident D whenever in. 25 P.M., CNA # 1 and ed they were going to lay in bed. As they lifted if the wheelchair with the dle of urine was observed if cushion. The resident's ed with urine. The as were wrinkled with is from the brief, and was CNAs put the resident to the bedpan to the did not urinate. CNA # 1 dent was sitting up in the they started their shift at she'd been up awhile." ed she had offered to lay in earlier, and she had i indicated the resident eted or repositioned since er shift at 2:00 P.M.		TAG	the monthly facility Quality Assurance Committee meeti and frequency and duration or reviews will be adjusted as needed. Completion Date: J 20, 2011	ng of

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	ETED
		155333	B. WIN			06/21/2	011
			_	STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	ę.		559 W L	LONGEST ST		
	EALTH AND LIVING	G COMMUNITY INC			IN47454		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		Minimum Data Set ent, dated 3/30/11,					
		ident scored a 5 out of 15					
		tus, with 15 indicating no					
	1	nent. The resident did not					
		symptoms, including					
		. The MDS assessment					
	1 -	ident required extensive					
		*					
	assistance of 2+ staff for transfer and toileting, was always incontinent of						
	bladder, and frequently incontinent of						
	I	S assessment indicated the					
		a current toileting					
		a current tonething					
	program.						
	A Care Summar	y, dated 4/13/11,					
	· ·	ner factors that contribute					
	·	.Urinary urgency AND					
		ce in toiletingResident					
		yer with assist of 2Type					
	of incontinence,						
		th urgency)Resident					
		movement. At times is					
	1	needs known or known in					
	time to be toilete						
		ent is incontinent of					
	_	rs include: NIDDM					
		tic use, need for assist for					
		es unaware of need to					
	void"	os anaware or need to					
	voiu						
	A Care Dlan dat	ed 2/21/11, indicated a					
	problem of Pote	ential for skin breakdown					

000226

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPLETED
		155333	B. WIN			06/21/2011
NAME OF I	PROVIDER OR SUPPLIER		'	STREET A	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			559 W I	LONGEST ST	
	EALTH AND LIVING				IN47454	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	\	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
IAG		LSC IDENTIFYING INFORMATION)	+	TAG	BLI ICILINE I)	DATE
	related to impair	•				
	incontinenceChronic rash/redness to					
		and periarea [sic]." The				
	1 **	ded: "Change incontinent				
	1 -	ossible after voiding or				
		t. Keep skin clean and				
	1 * *	hedule and prn [as				
		good pericare after				
	incontinence epis	sodes. Turn and				
	reposition every	bed check and PRN.				
	Reposition while	up in wheelchair."				
	A Care Plan, date	ed 3/4/11, indicated a				
	problem of "Resi	ident experiences bladder				
	incontinence R/T	[related to] impaired				
		ge incontinence." The				
	1 -	ded: "Keep call light in				
	1 **	oyer lift for toileting.				
		g, before and after meal				
		me] and prn. Offer				
	1	vo hours at night. Use				
		ent when in chair and				
	incontinence pad					
	incommence pau	in oou.				
	On 6/21/11 at 10	·20 A M during				
		e Director of Nursing				
		inistrator, the DON				
	1	nt D required transfer				
		•				
	1	. The DON indicated				
		eting schedule should be				
	before and after i	meals and at bedtime.				
	2 0 (/20/11	7.05 D.M. (1. 11.)				
		7:05 P.M., the Unit				
	Manager provide	ed CNA assignment				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333		A. BUII	LDING	NSTRUCTION 00	(X3) DATE COMP. 06/21/2	LETED	
	PROVIDER OR SUPPLIER		B. WIN	STREET A			
PAOLI H (X4) ID PREFIX TAG	summary s (EACH DEFICIEN REGULATORY OR sheets. The assig Resident D requi Hoyer, should be and was on a toil p-6a per schedule also indicated, ". before and after toileting every 2 3. On 6/21/11 at	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Inment sheet indicated red assistance of 2 with a returned every 2 hours, eting schedule of "10 e." The assignment sheettoilet upon rising, meals, hs and prn, offer hours at night" 12:10 P.M., the DON rent facility policy on		PAOLI, ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE
	"Skin Care and F Ulcer Prevention Program," dated policy included: prevention progr many factors. Th conditions along that may contribut pressure ulcers incontinenceCo chair-bound indi- impaired ability for pressure ulcers	ressure/Non-Pressure and Management September 2008. The "Managing a skin am is dependent upon ere are certain clinical with limited mobility atte to the development of 1. Urinary or bowel onsider all bed and viduals, or those with to reposition to be at risk					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155333	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP 06/21/	LETED
PAOLI HI		COMMUNITY INC	STREET. 559 W	ADDRESS, CITY, STATE, ZIP O LONGEST ST IN47454	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155333	B. WIN	G		06/21/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
PAOLI H	EALTH AND LIVING	COMMUNITY INC	559 W LONGEST ST PAOLI, IN47454				
(X4) ID		TATEMENT OF DEFICIENCIES	PROVIDER'S PLAN OF CORRECTION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
F0315 SS=D	Based on the resident sessessment, the for resident who enter indwelling cathetes the resident's clinic that catheterization resident who is incompropriate treatmurinary tract infect normal bladder further trace. Based on orinterview, are review, the ensure are for toileting appropriate maintain blain that she continent in and progression incontinent. March 201 residents r	dent's comprehensive acility must ensure that a rs the facility without an r is not catheterized unless cal condition demonstrates in was necessary; and a continent of bladder receives nent and services to prevent ions and to restore as much inction as possible. Abservation, and record a facility failed to sident dependent g, received a interventions to ladder function, was always in January 2011 assed to always at of bladder in 1, for 1 of 3 eviewed for	F0	315	F315 483.25(d) NO CATHET PREVENT UTI, RESTORE BLADDER 1. Resident D ware-assessed regarding her bladder function and is receivappropriate interventions to maintain bladder function. 2. residents that are dependent toileting have been identified an assessment has been completed including approprinterventions to maintain blace function. 3. The systemic chincludes any resident with a decline in continence or transwill be reviewed at the morniclinical meeting to determine the urinary assessment and of care needs to be revised regarding appropriate interventions to maintain blace function. If deemed necessal voiding diary will be initiated least 3 days and a new assessment and plan of care be completed. Education was provided for nursing staff regarding. Identifying reside with a decline in transfers and continence. Assessment of bladder incontinence.	All to for and intended ange sfers ang if plan dder ary, a for at exits d	07/20/2011

000226

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CC	ONSTRUCTION 00	(X3) DATE SUF COMPLETI		
ANDIEM	or course now	155333	A. BUII B. WIN	LDING		06/21/201	
			B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE LONGEST ST IN47454	l	
	PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL		559 W I	LONGEST ST	the int of ng kly for or the n daily nical w n of ln nd dents e ss of lent ne be cility	(X5) OMPLETION DATE	
	wheelchair On 6/20/11 Resident D wheelchair	was sitting in in her room. at 6:10 P.M., was sitting in a in her room. at 7:05 P.M.,			Date: July 20, 2011	euon	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333		(X2) M A. BUI		NSTRUCTION 00	(X3) DATE SURVI		
		155333	B. WIN			06/21/2011	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LONGEST ST		
PAOLI HI	EALTH AND LIVING	COMMUNITY INC		1	IN47454		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	CON	(X5) MPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	CNA # 1 in	dicated they					
	"usually lai	d (Resident D)					
	down betw	een 7:30 P.M.					
	and 8:00 P.	M." A request					
	was made a	at that time to do					
	a skin asses	ssment on					
	Resident D	whenever she					
	was laid do	wn.					
	On 6/20/11	at 7:25 P.M.,					
	CNA # 1 ar	nd CNA#2					
	indicated th	ney were going					
	to lay Resid	dent D down in					
	bed. As the	y lifted the					
	resident off	of the					
	wheelchair	with the Hoyer					
	lift, a pudd	le of urine was					
	•	n the wheelchair					
	cushion. Th	ne resident's brief					
	was saturated with urine.						
	The resider	nt's buttocks					
	were wrink	led with deep					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333		A. BUI	LDING	NSTRUCTION 00	COM	TE SURVEY IPLETED 1/2011		
	PROVIDER OR SUPPLIER		B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 559 W LONGEST ST PAOLI, IN47454					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE	
	indentation	s from the brief,						
	and was dark red. As the							
	CNAs put	the resident to						
	bed, they o	ffered the						
	bedpan to t	the resident, but						
	she did not	urinate. CNA#						
	1 indicated	the resident was						
	sitting up i	n the wheelchair						
	when they	started their shift						
	at 2:00 P.M	I., and "she'd						
	been up aw	hile." CNA#1						
	indicated s	he had offered to						
	lay the resi	dent down						
	earlier, and	she had refused.						
	CNA # 1 ir	ndicated the						
	resident ha	d not been						
	toileted sin	ce she had						
	started her	shift at 2:00						
	P.M.							
	The clinica	l record of						
	Resident D	was reviewed						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155333	B. WIN	G		06/21/2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LONGEST ST	
PAOLI HI	EALTH AND LIVING	COMMUNITY INC			IN47454	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	on 6/21/11 at 9:25 A.M.					
	Diagnoses	included, but				
	were not lin	mited to, Edema,				
	Congestive	Heart Failure,				
	and Demen	ntia.				
	A quarterly	Minimum Data				
	Set [MDS]	assessment,				
	dated 1/6/1	1, indicated the				
		ored a 5 out of a				
	total of 15	for cognitive				
		15 indicating				
		nent. The MDS				
	_	indicated the				
		quired extensive				
		of 2 + staff for				
		d was "always				
		of bowels and				
	bladder.					
		n, initially dated				
	7/16/10 and	d revised				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				INSTRUCTION 00	(X3) DATE S COMPL		
		155333	A. BUII B. WIN			06/21/2	011
NAME OF F	ROVIDER OR SUPPLIER		_		ADDRESS, CITY, STATE, ZIP CODE		
PAOLI HI	EALTH AND LIVING	COMMUNITY INC			LONGEST ST IN47454		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	2/21/11, ind						
	"Potential for skin						
	breakdown	R/T [related to]					
	impaired m	obility,					
	incontinenc	eeChronic					
	rash/rednes	ss to abd. folds					
	and periare	a." The					
	approaches	indicated,					
	"Keep skin	clean and dry.					
	Change inc	ontinent pad as					
	soon as pos	ssible after					
	voiding or	bowel					
	movement.	Toilet per					
	schedule."						
	A Care Plan	n, dated 2/21/11,					
	indicated a	problem of					
	"Potential f	for skin					
	breakdown	related to					
	impaired mobility,						
	incontinenc	ceChronic					
	rash/rednes	ss to abdominal					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333			LDING	NSTRUCTION 00	(X3) DATE COMPI 06/21/2	LETED	
	PROVIDER OR SUPPLIER EALTH AND LIVING		STREET ADDRESS, CITY, STATE, ZIP CODE 559 W LONGEST ST PAOLI, IN47454				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE
	folds and periarea [sic]."						
	The approa	ches included:					
	"Change in	continent pad as					
	soon as pos	ssible after					
	voiding or	bowel					
	movement.	Keep skin clean					
	and dry. To	ilet per schedule					
	and prn [as	needed],					
	provide go	od pericare after					
	incontinend	ce episodes. Turn					
	and reposit	ion every bed					
	check and l	PRN. Reposition					
	while up in	wheelchair."					
	indicated a "Resident e bladder inc [related to] cognition a incontinence	nd urge					
	ирргоаспез	meraded. Reep					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333		A. BUII	LDING	NSTRUCTION 00	(X3) DATE S COMPL 06/21/2	ETED	
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE LONGEST ST		
PAOLI H	EALTH AND LIVING	COMMUNITY INC		PAOLI,	IN47454		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	call light in reach. Provide						
		for toileting.					
	1	rising, before					
		eal [sic], hs [at					
		nd prn. Offer					
	toileting ev	ery two hours at					
	night. Use	brief under					
	resident wh	nen in chair and					
	incontinenc	ce pad in bed."					
	Data Set as 3/30/11, incresident sec cognitive stresident did behavior sy including reThe MDS a indicated the required extends.	ored a 5 for tatus. The d not exhibit amptoms, ejection of care. assessment he resident					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE S COMPLI	ETED	
		155333	B. WIN			06/21/20)11
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LONGEST ST		
PAOLI HI	EALTH AND LIVING	COMMUNITY INC		PAOLI,	IN47454		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE.	DATE
	transfer and	d toileting, was					
	always inco	ontinent of					
	bladder, an	d frequently					
	incontinent	of bowel. The					
	MDS asses	sment indicated					
	the residen	t was on a					
	current toil	eting program.					
	An "Assess	sment of Urinary					
	Incontinend	ce," dated					
	3/30/11, inc	dicated, "What					
	are the resi	dent's current					
	voiding pat	terns? Freq.					
	incont [free	quently					
	incontinent	.]. Does the					
	resident red	quire physical					
	assistance t	for toileting?					
	Yes[two]	assistDoes the					
	resident ha	ve a prior history					
	of urinary i	ncontinence:					
	Yes, function	onalCan the					
	resident co	mprehend and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		INSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155333	B. WIN			06/21/2011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LONGEST ST	
PAOLI H	EALTH AND LIVING	COMMUNITY INC		1	IN47454	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	follow through on					
	education and instructions?					
	No. Can th	e resident				
	identify uri	nary urge				
	sensation?	No, Can the				
	resident lea	ırn to inhibit or				
	control the	urge to void				
	until reachi	ing a toilet:				
	No"					
	A Care Sur	nmary, dated				
		dicated, "Other				
		contribute to				
	incontinend	eUrinary				
		ND need for				
	assistance i					
		Resident transfers				
		with assist of				
	2Type of incontinence, Mixed (stress incontinence					
	`					
	with urgency)Resident 'leaks' with any movement.					
	Taks Willi	any movement.				

000226

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155333		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 00	(X3) DATE COMPI 06/21/2	LETED	
	PROVIDER OR SUPPLIER		p. ((1)	STREET A	DDRESS, CITY, STATE, ZIP CODE	ļ	
	EALTH AND LIVING				IN47454		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	EΕ	(X5) COMPLETION DATE
	At times is unable to make						
	needs known or known in						
	time to be						
	toiletedA	nalysis of					
	Findings]	Resident is					
	incontinent	of urine. Risk					
	factors incl	ude: NIDDM					
	[diabetes],	diuretic use,					
	need for as	sist for transfers,					
	at times un	aware of need to					
	void"						
	On 6/21/11	at 10:20 A.M.,					
	during inte	rview with the					
	Director of	Nursing [DON]					
	and Admin	istrator, the					
	DON indic	ated Resident D					
	required tra	ansfer with a					
	Hoyer lift,						
	previously required a						
	stand-up lift. The DON						
	1 -	desident D's					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	INSTRUCTION 00	(X3) DATE S COMPL		
		155333	B. WIN			06/21/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE LONGEST ST		
PAOLI H	EALTH AND LIVING	COMMUNITY INC		1	IN47454		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	1	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	toileting sc	hedule should be					
	before and	after meals and					
	at bedtime.	The					
	Administra	tor indicated she					
	thought the	resident was					
	able to tell	staff if she					
	needed assi	istance.					
	On 6/21/11	at 12:00 P.M.,					
	the DON ir	ndicated the					
	resident ha	d a "3 day					
	voiding pat	tern" done in					
	March whi	ch indicated the					
	resident wa	is incontinent at					
	night only.	The DON					
	indicated th						
	looking for						
		tion. The DON					
	indicated th	ne facility would					
		ner 3 day voiding					
	•	the resident to					
	l ^	when she was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333		LDING	NSTRUCTION 00	(X3) DATE COMPI 06/21/2	LETED	
	PROVIDER OR SUPPLIER		STREET A	ODDRESS, CITY, STATE, ZIP CODE ONGEST ST IN47454		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E	(X5) COMPLETION DATE
	incontinent	. The DON				
	indicated sl resident ha	he thought the d been				
	incontinent that the MI time period been wrong 2. On 6/20/the Unit M CNA assign The assign indicated R required as with a Hoy turned ever was on a to of "10p-6a The assign indicated,"	in January, and DS from that I could have g. 11 at 7:05 P.M., anager provided ment sheets.				
	meals, hs a	nd prn, offer				

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155333	(X2) MULTIPLE CONSTRUCTION 00			(X3) DATE SURVEY COMPLETED	
			A. BUII B. WIN			06/21/2	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
PAOLI HEALTH AND LIVING COMMUNITY INC				1	LONGEST ST IN47454		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
	toileting ev	ery 2 hours at					
	night"	•					
	C						
	3. On 6/21/	11 at 11:25					
	A.M., the I	OON provided					
	the current	facility policy					
	on bladder incontinence						
	management, revised 10/06.						
	The policy included:						
	"Assessment, 1. Obtain						
	history of medical and physical problems related to bladder function2. Establish a baseline assessment of bladder voiding patterns by completing a 3-day bladder						
	record to de	etermine					
	frequency,	timing and					
	amounts of	voids, number					
	of incontin	ent					
	episodes]	This assessment					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/12/2011 FORM APPROVED OMB NO. 0938-0391

I '		IDENTIFICATION NUMBER:		MULTIPLE CO	NSTRUCTION 00	(COMPLETED	
155333		155333	A. B ¹ B. W	UILDING ING			06/21/2011	
NAME OF PROVIDER OR SUPPLIER					DDRESS, CITY, STA	ATE, ZIP CODE		
PAOLI HEALTH AND LIVING COMMUNITY INC				559 W LONGEST ST PAOLI, IN47454				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY F	ULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	`	LSC IDENTIFYING INFORMAT		TAG		ED TO THE APPROPRIATE ICIENCY)	DAT	
		completed every	·					
	one to two	hours for at lea	st					
	three days	in order to						
	determine	voiding						
	patterns4	. The assessme	nt					
	will be con	npleted and						
	toileting pr	ograms						
	implemente	ed based upon						
	individual needIf the							
	resident has an irreversible		e					
	condition and/or would not		ot					
	benefit from	n further						
	evaluation	or treatment (i.	e.					
	no memory	recall, require	s					
	extensive a	ssistance with						
	transfers)	then the plan	of					
	care should address							
	intervention	ns that are						
	directed at	prevention						
		imization of						
	urinary inc	ontinence						
	complication	onsInclude						
ı								
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Ever	nt ID: UG191	1 Facility I	D: 000226	If continuation she	eet Page 26 of	29

UG1911

Page 26 of 29

AND PLAN OF CORRECTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155333		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/21/2011		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
PAOLI HEALTH AND LIVING COMMUNITY INC				1	LONGEST ST IN47454		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
	toileting sc	chedules, fluid					
	intake, pro	tective garments					
	and pads a	s appropriate in					
	the plan of	careFunctional					
	Incontinen	ce occurs in					
	residents w	ho would					
	otherwise be continent but						
	due to physical or cognitive						
	problems or various						
	medications are unable to						
	reach the toilet facilities in						
	time. Causes include						
	confusion; dementiapoor						
	mobilityor excessive						
	distance from the toilet						
	facilitiesManagement						
	Options, Prompted voiding,						
	habit trainingExercise programsStaff and						
	symptom management"						
	This Feder	al Tag relates to					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155333	(X2) MULTIPLE CC A. BUILDING B. WING	00		E SURVEY PLETED (2011		
NAME OF PROVIDER OR SUPPLIER PAOLI HEALTH AND LIVING COMMUNITY INC			STREET ADDRESS, CITY, STATE, ZIP CODE 559 W LONGEST ST PAOLI, IN47454					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
		IN00091128.						
	3.1-41(a)(2	2)						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDE		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155333	B. WING		06/21/2011	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 559 W LONGEST ST						
PAOLI HI	IN47454					
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE	